DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 - 06

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/01/2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 424.57, 440.230, 441, Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY (2003) $000.00
b. FFY (2004) $000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Pages 3, 7.31(a), 7.3.1(b), 7.3.1(c), 7.5.2, 12, & 13
Attachment 3.1-B, Pages 3, 11, 24, 25, 25.1, 31.1, & 39
Attachment 4.19B, Page 20.14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Pages 3, 7.31(a), 7.3.1(b), 7.3.1(c), 7.5.2, & 12
Attachment 3.1-B, Pages 3, 11, 24, 25, 25.1, & 31.1
Attachment 4.19B, Page 20.14

10. SUBJECT OF AMENDMENT:

Durable Medical Equipment Coverage and Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mike Robinson

13. TYPED NAME: Mike Robinson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 8/14/03

16. RETURN TO:

Frances McGraw
Eligibility Policy Branch
Department for Medicaid Services
275 East Main Street 6W-C
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 19, 2003

18. DATE APPROVED:
October 31, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Susan Cuerdon

21. TYPED NAME:
Susan Cuerdon

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
This is a revised CMS-179. The original was received on March 19, 2003 and signed on March 19, 2003.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

X Provided: ___No limitations _X_With limitations*___Not Provided.

c. Chiropractors' services.

X Provided: X No limitations __With limitations* ___Not provided.

d. Other Practitioners' Services

X Provided: ___No limitations _X With limitations* ___Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or
by a registered nurse when no home health agency exists in area.

_X Provided:__No limitations_X With limitations*___Not provided.

b. Home health aide services provided by a home health agency.

X Provided: ___No limitations _X With limitations* ___Not provided.

c. Medical supplies suitable for use in the home.

X Provided: ___No limitations _X With limitations*___Not provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place or residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies Suitable for Use in the Home.

Each provider desiring to participate as a medical supply provider must be a participating Medicare Provider and sign a provider agreement with the Department for Medicaid Services.

1. The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity.

2. Coverage of medical supplies for use by patients in the home, are based on medical necessity.

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. The criteria used in the determination of medical necessity Includes an assessment of whether the item is:
   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability or other medical condition;
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver or the provider;
   e. Provided in the recipient's residence, in accordance with generally accepted standards of good medical practice, where the service may , for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent lay person standard; and,
   g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements for recipients under twenty-one (21) years of age.

4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary and reasonable.

7.d. Physical therapy, occupations therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, or speech pathology services provided by a home health agency must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Audiology services are not provided under this component. Physical therapy, occupational therapy or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

- ❖ A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program.

(3) A patient "locked-in" to one pharmacy due to over-utilization may receive pharmacy services only from his/her lock-in provider except in the case of an emergency or by referral.

(4) If authorized by the prescriber, a prescription may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered.

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the early, periodic, screening diagnosis and treatment program (EPSDT).

c. Prosthetics and Orthotics

Prosthetic and orthotic devices are covered in accordance with Attachment 3.1-A, page 12.

d. Eyeglasses

Eyeglasses are not covered for adults. Eyeglasses are covered for children through the vision program.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

_X_ Provided ___No limitations _X_ With Limitations* ___Not Provided

*Description provided on attachment.

State/Territory Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERIVCES PROVIDED TO THE MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

a. A provider must be Medicare and Medicaid certified. Items must be medically necessary.and, if required, prior authorized.

b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.

c. Any item designated by a covered HCPCS codes being reimbursed at $150.00 or more will require prior authorization.

d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.

e. The following general types of durable medical equipment, medical supply, prosthetics or othotics are excluded from coverage under the durable medical equipment program:

1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
3. Physical fitness equipment, such as exercycles and treadmills;
4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
6. Items considered educational or recreational.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State Law, furnished by
Licensed practitioners within the scope of their practice as defined by State Law.

a. Podiatrists' services
X Provided:___No limitations X With limitations*__Not Provided.

b. Optometrists' services.
X Provided:__No limitations X With limitations*__Not Provided.

c. Chiropractors' services.
X Provided: X No limitations __With limitations*__Not provided.

d. Other Practitioners' Services
X Provided:__No limitations X With limitations*__Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or
by a registered nurse when no home health agency exists in area.
X Provided:__No limitation X With limitations*__Not provided.

b. Home health aide services provided by a home health agency.
X Provided:___No limitations X With limitations*__Not provided.

c. Medical supplies suitable for use in the home.
X Provided:__No limitations X With limitations*___Not provided.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
X Provided: ___No limitations X With limitations*___Not provided.

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERIVCES PROVIDED TO THE MEDICALLY NEEDY

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27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

_X_ Provided ___No limitations _X_ With Limitations* ___Not Provided

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Homehealth Aide Services

Homehealth aide services must be ordered by a physician, prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies Suitable for Use in the Home

Each provider desiring to participate as a medical supplier provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

1. Coverage of medical supplies for use by patients in the home, is based on medical necessity.

2. Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. The criteria used in the determination of medical necessity includes an assessment of whether the item is:

   a. Provided in accordance with 42 CFR 440.230;

   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;

   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;

   d. Provided for medial reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;

   e. Provided in the recipient's place of residence, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, or speech pathology services provided by a home health agency must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Audiology services are not provided under this component. Physical therapy, occupational therapy, or speech pathology services provided by a medical facility are not provided under this component.

- ❖ A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program.

(3) A patient "locked-in" to one pharmacy due to over-utilization may receive pharmacy services only from his/her lock-in provider except in the case of an emergency or by referral.

(4) If authorized by the prescriber, a prescription may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered.

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the early, periodic, screening diagnosis and treatment program (EPSDT).

c. Prosthetics and Orthotics

Prosthetic and orthotic devices are covered in accordance with Attachment 3.1-B, page 39.

d. Eyeglasses

Eyeglasses are not covered for adults. Eyeglasses are covered for children through the vision program.

State/Territory Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERIVCES PROVIDED TO THE MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

a. A provider must be Medicare and Medicaid certified. Items must be medically necessary.and, if required, prior authorized.
b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
c. Any item designated by a covered HCPCS codes being reimbursed at $150.00 or more will require prior authorization.
d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
e. The following general types of durable medical equipment, medical supply, prosthetics or othotics are excluded from coverage under the durable medical equipment program:
    1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
    2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
    3. Physical fitness equipment, such as exercycles and treadmills;
    4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
    5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
    6. Items considered educational or recreational.

XIV. Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice minus twenty-two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have a HCPC code, and all other miscellaneous codes will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary change.

c. DME items that do not have HCPC codes and have been determined by the department to be covered will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases with codes of K0009 and K0014 will require prior authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (15) percent, not to exceed the supplier's usual and customary charge.